radiotherapy gives good results in patients with stage I,[5] but there is still controversy regarding the best treatment modality for breast cancer.

We believe that modified radical mastectomy is, at present, the procedure of choice for *most* patients with potentially curable carcinoma of the breast. This modality appears to cure the disease in patients in whom cancer is localized (about 20 percent of patients with breast cancer) and at the same time provides valuable staging information. The latter can be used to establish prognosis since the number of nodes involved is the single factor most predictive of 10-year and 20-year survival,[6] and most important the information obtained from the pathologic examination of the axillary lymph nodes is vital to ascertain the need for adjuvant therapy.

Finally, we believe it is unfair to imply or state that Halsted did not practice what he preached, that his operation was designed only to promote the economics of surgery, that he charged exhorbitant fees and that he avoided patients at all times. It is unjust to minimize his contributions in the field of asepsis, one of the greatest advances in surgery, pretending they represented only a romantic event. If it was important for the author to describe in detail Halsted's drug addiction and character problems it might also have been fair to point out that it was William S. Halsted's prodigious mind that laid the structure for the surgical residencies, the system used in training surgeons throughout the world today.

CARLOS PELLEGRINI, MD
Assistant Professory of Surgery
ORLO H. CLARK, MD
Associate Professor of Surgery
University of California, San Francisco
Surgical Service
Veterans Administration Medical Center
San Francisco

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TO THE EDITOR: I wish to commend you on your publication of Cordelia Shaw Bland's article on the Halsted mastectomy in your June issue. I felt a little ill inside when I read it.

It has always amazed me how much we physicians are influenced in how we practice medicine by those who often have so little direct contact with the kind of medicine *we* see on a daily basis. I can remember 25 years ago being told "pure gospel" by physicians who had never, and would never, be directly involved in the day-to-day caring for people.

As physicians, we are privileged to have the most intimate look at the best and worst of the human condition, and, if we seriously think or care at all about what we spend most of our time doing, I rather think our judgment will be quite good most of the time. But can we embark on what might turn out to be a better treatment when we are constrained by our attorney friends, and in fact our peers, to limit our treatments to the so-called community standard?

NORMAN C. HEADLEY, MD
Cameron Park, California

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TO THE EDITOR: I look forward each month to THE WESTERN JOURNAL OF MEDICINE as a source of information regarding medical developments in the western states.

I write you now, however, to register a firm voice of displeasure regarding the publication of the article by Cordelia S. Bland in the June issue.

The article is filled with innuendo and extrapolation.

There is lack of logic, specious reasoning and repeated assumption that play no role in a medical journal. Reference to nonfactual material and to authors with an acknowledged bias is not appropriate.

Publishing the article represents an extremely poor editorial philosophy. The article falls well below the standard I expect from you.

SONNY P. COBBLE, MD
Los Angeles

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TO THE EDITOR: Congratulations on the great article by Cordelia S. Bland. I thoroughly enjoyed it. It was written objectively and scientifically. THE WESTERN JOURNAL OF MEDICINE showed very good taste in accepting it. And, I congratulate the author on a job well done. Keep up the good work.

GEORGE CRILE, Jr, MD
Emeritus Consultant
Department of General Surgery
Cleveland Clinic
Cleveland

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TO THE EDITOR: The article on the Halsted mastectomy in the June issue has proved a delight to